

# Montana Central Tumor Registry

## Newsletter

### How the MCTR Data Are Used

The MCTR receives an average of 75 requests a year for summary data about cancer in Montana. A third of the requests come from Cancer Registrars or other staff of our partner hospitals around the state, who need the data for grant writing, planning, and evaluation. Between a quarter and a third of the requests come from physicians, city and county health departments, partners within the Montana Department of Public Health and Human Services, other state agencies, and federal agencies.

The MCTR is beginning to receive more requests from teachers, students, and university researchers for de-identified data sets. We recently created a de-identified data set for the Rocky Mountain Tribal Epidemiology Center to investigate possible differences in stage at diagnosis and survival between American Indian and White women with breast cancer in Montana.



Last year, we participated in a national recruitment effort to encourage sisters of women with breast cancer to enroll in **The Sister Study** ([www.sisterstudy.org](http://www.sisterstudy.org)), a comprehensive study of environmental and genetic risk factors for breast cancer. We searched the MCTR for women with breast cancer who met study selection criteria, then contacted their physicians to ask them to distribute informational packets to their patients. The response was very positive: 134 physicians agreed to send packets to their patients and 65 agreed to distribute informational brochures in their waiting rooms. A total of 1,287 Montana women received the Sister Study's recruitment materials through their physicians.

The Montana DPHHS uses MCTR data in-house in several ways. We often respond to concerns expressed by Montana citizens that there may be excess cancer in their regions. We created a quarterly Surveillance Report series based primarily on data in the MCTR. We recently reviewed six years of treatment records and determined that 83% of women with stage I breast cancer who had breast-conserving surgery received follow-up radiation therapy according to treatment guidelines, better than the national performance of 76%.



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## Lung Cancer in Montana 2002-2006

Incidence 64.7 / 100,000

Mortality 51.0 / 100,000

### Stage at Diagnosis

Local	15%
Regional	24%
Distant	48%
Unstaged	12%

### Five Year Survival by Stage at Diagnosis 1997-2006

Local	52%
Regional	19%
Distant	3%

## Focus On: Lung Cancer

Lung cancer has one of the strongest one-to-one relationships with a risk factor of any cancer: more than 90% is attributable to smoking. Without tobacco, lung cancer would be rare. A few patients develop lung cancer without ever smoking: approximately 5% of cases are attributable to radon exposure, 3% to exposure to second-hand smoke, and the remainder to environmental or occupational exposures.

Some carcinogens increase the risk of lung cancer although exposure to them must be chronic and concentrated, typically in an occupational setting. Occupations with potential exposure to carcinogens causing lung cancer include agriculture, brake repair, chrome plating, construction, demolition, electronics manufacturing, electroplating, insulation, foundry work and metal casting, heating and air conditioning, mechanics, mining, pipefitting, printing, quarrying, roofing, sand blasting, sand and gravel operations, shipyards, smelting, tanning, welding, and wood preservation.

The prevalence of smoking is declining in Montana. A decrease in the incidence of lung cancer is expected to follow after a lag of about 20 years. As fewer cases are caused by smoking, a greater proportion of the residual cases will be attributable to occupational or other environmental exposures.

*More than 90% of cases of lung cancer are preventable.*

## Meet Jeanne Andre, CTR



I have been a cancer registrar at St. Peter's Hospital in Helena for the past eighteen years, so long ago that each cancer case was a one page paper abstract. Today our abstracts are multiple pages consisting of many data and text fields covering a broad spectrum of collected cancer statistics. Registry work is continually evolving, and forever challenging, making this a very rewarding career. In 2000 I helped the Cancer Program of St. Peter's become the third hospital in Montana to become an accredited cancer program recognized by the Commission on Cancer. As a certified cancer registrar, I coordinate the cancer program, supervise the registry, and serve as the current President of the Montana Cancer Registrars Association.

When I am not at my job, I enjoy spending my down-time camping, fishing, hunting, white-water rafting, and gardening. Winter months I try to do some cross-country skiing when I am not shoveling snow and splitting firewood. I also love to travel and have visited many of the lower 48 states, Mexico and China.



## Certificate of Excellence Recipients

The following hospitals received a certificate for the 2008 Third Quarter, acknowledging their timeliness in reporting. Ninety percent of their cases were reported within 12 months.

### Hospital

### City

Bozeman Deaconess Hospital  
Billings Clinic  
St Vincent's Hospital  
Sletten Cancer Institute  
Northern Montana Hospital  
Central Montana Hospital  
Phillips County Hospital  
Kalispell Regional Hospital  
Yellowstone Path Institute

Bozeman  
Billings  
Billings  
Great Falls  
Havre  
Lewistown  
Malta  
Kalispell  
Billings

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## Registrar Information Forms

The MCTR still would like to receive your registrar information forms that were mailed to you in September 2008. If you haven't sent your form back the MCTR staff will be contacting you for your email address.

By using e-mail we can send you:

- ✦ Information about upcoming Tumor Registry training opportunities;
- ✦ Tumor Registry reporting updates or changes;
- ✦ Quarterly Hospital Feedback reports on reported cases;
- ✦ *Quarterly Surveillance Reports, Special Reports, and MCTR Newsletters;*
- ✦ News and updates on national Tumor Registry standards;
- ✦ Successes on the Montana Comprehensive Cancer Control Program; and
- ✦ MCTR Abstracting Manual page updates and revisions.

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## Montana Central Tumor Registry Audit

The Montana Central Tumor Registry (MCTR) will be audited by the Centers for Disease Control and Prevention (CDC) National Program of Cancer Registries (NPCR) during August 17-28, 2009. The CDC requires the MCTR to undergo an audit once every five years. Many of our hospitals have participated in this audit in the past so you may be familiar with the event. In order for the MCTR data to be audited, the auditors must go to the source data - the medical record.

The audit will include a casefinding review and a data quality review. Nine hospitals will be randomly selected to participate. Thirty-three cases at each facility will be randomly selected for review for data quality. *It's important to remember that your data are not being audited; the MCTR data are being audited.* If you are selected to participate, the auditors (contractors from Macro International, Inc.) will spend one day at your hospital conducting the audit.

Important details of the audit:

- Your data are not being audited, the MCTR data are
- The data are kept completely secure and confidential
- Results will not be presented by hospital, only summary data for the MCTR will be released
- You will be notified ahead of time with ample time to prepare

More information will be coming. If you have questions about the audit, please e-mail Debbi Lemons at [dlemons@mt.gov](mailto:dlemons@mt.gov) or call at (406) 444-6786.

## Quality Improvement: Tobacco and Alcohol History Usual Occupation and Usual Industry

Tobacco, alcohol, and occupational exposures to possible carcinogens are important epidemiologic data. They are interrelated. Tobacco, alcohol, and the combination of the two increase the risk of many cancers throughout the body. Other carcinogens overlap with tobacco and alcohol in the organs at highest risk.

The MCTR is often asked to estimate the cancer burden attributable to smoking and alcohol consumption or to participate in studies of potential environmental or occupational causes of cancer. To do this properly, we need information on tobacco and alcohol history (prior as well as current use) and usual occupation and industry. Figures 1 and 2 describe reporting for tobacco and alcohol history. Reporting has increased from about 4% in 1990 to 61% for tobacco and 54% for alcohol in 2005. The MCTR's goal for reporting tobacco and alcohol history is 85% of all cases reported.

In a recent sentinel event monitoring activity, we found a patient diagnosed with mesothelioma at an atypically young age. We might have had to undertake a case investigation but the usual occupation and industry fields indicated the patient had probable exposure to asbestos. These data were sufficient to explain the case and avoid an investigation which would have been time consuming for MCTR staff and the reporting physician or institution, and possibly intrusive for the patient if the physician had to recontact him to enquire about exposure history.

Usual occupation and industry are 40-character text fields that provide useful clues to possible exposures. All patients age 14 years and older should have usual occupation and industry recorded; often this will be "student" for teens. However, some teens work on family farms and some have other jobs; these have a bearing on possible exposures. Homemakers may not have a history of working outside the home but the fields should not be left blank. We cannot distinguish between a blank that means a woman never worked outside the home and a blank that means "unknown." Write in "homemaker." Self-employed individuals should have a description of the basic activities of their occupation, for example, "attorney" or "construction" or some other indication of their usual tasks. Figures 3 and 4 show that reporting for occupation and industry has increased from about 2% in 1990 to about 50% in 2005. Again, the goal is to have 85% of all cases reported with occupation and industry.

Cancer typically affects the elderly so many patients are retired. "Retired" is not acceptable for the occupation and industry fields. Fill in usual occupation and industry with reference to what the patient did for most of his or her working life. Skip the phrase "retired from" and include as much about occupation and industry as possible.

Figure 1. Tobacco history

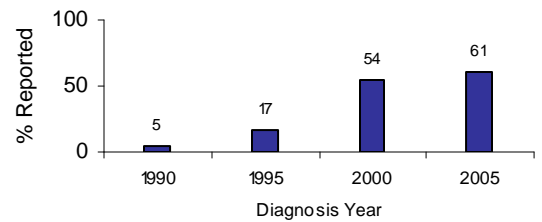


Figure 2. Alcohol history

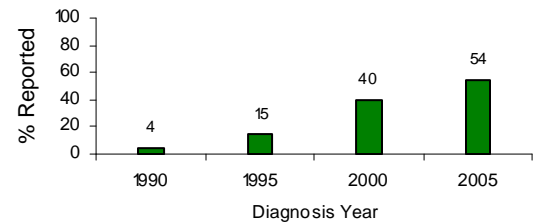


Figure 3. Usual occupation

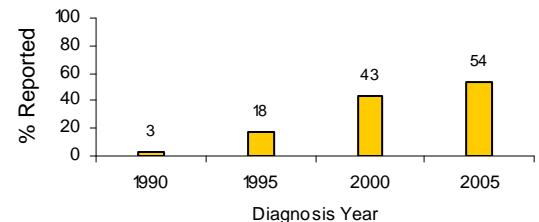


Figure 4. Usual industry

